

MEMORANDUM

TO: Margaret Sandberg.
Assistant Commissioner
FROM: Q.A. & Protective Services Division
RE: Response to the Residential Facilities Division position
paper "Commitment to Excellence" DATE: 7-3-86

On June 23, 1986 the Residential Facilities Division issued a statement of vision for a "new" role for state facilities within the mental health system. The QA/Protective Services Division recognizes that these ideas are a draft response to issues being raised by external forces and by the CEO's as system leaders. The many issues that are addressed all assume importance as we seek a long range plan for an effective mental health system in Minnesota. We will not attempt a fine grained analysis of the positions expressed in this paper at this time. However, we do have several issues that we would like to raise.

First, a State Hospital may change its name to Regional Treatment Center, but the public still sees a "state farm," "red roof hotel" and a place of last resort: that is, the most restrictive alternative to handling community problems, cheaply and out of sight! What is required to change these views are demonstrably effective programs that place the clients' needs first, effective discharge planning conducted jointly with counties, and a strong aftercare system. In making the transition from state hospital to regional treatment center, we recommend that improvements in treatment and habilitation programs, Improved discharge planning, and a strong aftercare system be the top three goal areas prioritized for the initial phase of the transition.

In light of image problems, regional centers may wish to review the negative effects of some current treatment programs that tend towards reinstating the restrictive, punishing, controlling, over-protective vestige of custodial care. Once "open hospitals" were brought about, it wasn't long before an insidious trend began whereby doors were again locked, and treatments from the past returned -- such as seclusion, restraint

chairs, four-point restraint, cuffs, camisoles, standing boxes, posey boards, long hours of isolation, and gown and robe. A recent example of this return to restrictive "treatment" programs is the RFM Policy Number 7000 (31 January 1986).

The second issue concerns the apparent absence of any reference to the Department's Quality Assurance Plan or even an intention to coordinate with our Quality Assurance/Protection and Advocacy system. This may reflect the current weakness of a decentralized Quality Assurance system in which each CEO sets his or her own priorities and standards rather than participating in establishing and meeting standards appropriate to a comprehensive residential/mental health system.

If DHS is to transfer additional authorities and responsibility to the CEO's as recommended in this paper, a well developed outcome-oriented QA monitoring system should be established by the Department of Human Services, and the CEO's position descriptions should be revised so that these increased authorities are written in measurable terms with appropriate performance indicators. In other words, the Department must be assured of its own capacity to effectively monitor the performance of CEO's and the effectiveness of the programs they administer. Without this capacity, the Department would be ill advised to increase CEO authorities and autonomy in fiscal and legal matters.

Third, it was suggested that the CEO's and regional centers could move from "state operated" facilities to a private entrepreneur approach, including such matters as total control over expenditures, revenues, contracts, and union negotiation. It is not clear how this would be achieved, and there is no indication that the CEO's have thought through some of the other implications. For example, let's assume that the CEO's could be private entrepreneurs. They would face all the risks and added liabilities of the private sector. No longer would they have a limit on civil suit awards or the luxury of being bailed out when over budget. Nevertheless, the state and DHS may want to explore this possibility more fully as the state facilities plan the

transition to fully regional treatment centers; the achievement of deinstitutionalization may require that the state no longer manage the mental health system.

We question the assumption that "residual" client populations are more difficult and that concentrations of these difficult clients, along with reduced staff, will produce regional center problems. Why are we so quick to blame the client for our problems? Regional centers have almost a ill staffing ratio. The issue is not the number of staff, but rather, non-treatment related priorities in hiring and poor utilization of the staff positions available. Hiring and placement decisions are matters of critical importance if professional staff are to effectively facilitate clients' achievement of treatment goals. A related barrier to effective treatment for "residual" populations is that there has never been sufficient funding appropriated to fulfill the staff and program development goals of our own State Quality Assurance Plan. We submit that the "problems" are resolvable, but only if we maintain the perspective that the problems are fiscal and administrative rather than client-induced.

The regional centers are attempting to sell the image that they have special expertise in behavior management, medication monitoring and adjustment, and the handling of behavior problems of the elderly. While we would agree that this direction makes sense in terms of a future role for the regional centers, we think that this will require a considerable investment by DHS in program development (see state Q.A. Plan, pp. 11-19) in order for the regional centers to be in a position to truly deliver on this promise.

The form of governance suggested in the paper, that of a corporate structure, should be given serious consideration by the Department. However, as presently conceptualized, there is a real risk that the Board of Directors may become an incestuous body. We recommend that like other corporations, this Board should be open and Include the representation of management personnel from the DHS program divisions, licensing, quality

assurance, and outside constituency groups (there may be others). Moving to a corporate structure would demand that we all work together towards achieving the same goals. This type of unity would greatly benefit the consumers of our service system. It will require a centralized, consistent Quality Assurance monitoring system so that effective treatment and habilitation programs are provided to all residents of state facilities.

We think that the proposed corporate structure can only be achieved by devoting considerable resources at the present time to an intensive, long-term planning process. The state should institutionalize this long-term planning process rather than waiting to react to short-term actions of the legislature. A few of the most important issues for the corporate Board to consider include:

1. Plans for future capital expenditures:

While it is important to maintain and improve current facilities in a timely and cost-effective manner, new capital construction should not be entered into lightly. As deinstitutionalization proceeds, and the regional centers transition to a "mobile service delivery system," both staff and residents will have decreased needs for office, residential, treatment, and leisure space. Plans also need to be made for cost effective utilization of surplus buildings.

2. Phasing out programs/new program development:

These issues need to be considered in relation to #1 above. The state must plan proactively for phasing out certain treatment programs and developing new programs for underserved populations. This requires good needs assessment data as well as an intensive planning effort. The state should also evaluate the issue of potential closure(s) as we move toward full regionalization rather than waiting for legislative mandates to come down. A plan should be developed for transitioning human resources as well as staff training needs.

3. Coordination with County Agencies:

In light of the recent Legislative Auditor's report on state services for the Mentally Ill and the Mentally Retarded, we are disappointed that no coverage was devoted in the paper to this important need. It is essential that regional treatment centers and counties develop and implement a better coordinated system for discharge planning and aftercare services in order to reduce the state hospital "revolving door" and to improve the quality of life for discharged clients. It is critical that the corporate Board plan for how decisions will be coordinated with the county case manager. The paper gives the impression that the CEO's, rather than the case managers, will decide which services are most appropriate in the region for individual clients. This would clearly represent a conflict of interest for the state.

4. Funding Issues:

The proposed shift in funding from a per diem rate to "fees for services" should be studied and a plan developed for phasing in new funding mechanisms while gradually phasing out the current system.

5. Increased CEO authorities:

We agree that the CEO's should be measured according to the outcomes of their management of facilities and resources. The desired outcomes should be well defined and effectively monitored by the Department. External barriers should be factored in, but not allowed to function as an "excuse" for poor performance. With increased authority comes increased responsibility and the potential for decreased job security for the CEO's, particularly if a true "corporate structure" is to be adopted.

We are in agreement with the authors of Commitment to Excellence that both the Department and the regional centers can and should do much to improve communications, cooperation.

planning, and evaluation of services. The challenge of the 80's is to become one corporate family able to effectively deal with the many complicated issues that require our attention so that we can do more than talk about reaching the level of excellence that we all want for Minnesota's residential/mental health system.